2026 Measures Under Consideration List

CMS Quality Measurement Needs and Priorities Report

Overview

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The pre-rulemaking process is mandated by section 3014 of the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148, enacted on March 23, 2010), which added Section 1890A to the Social Security Act (the Act), and requires the HHS to establish a federal pre-rulemaking process for the selection of certain categories of quality and efficiency measures for use by HHS. These measures are described in section 1890(b)(7)(B) of the Act.

Every year, the Centers for Medicare & Medicaid Services (CMS) engages partners and advances transparency by inviting interested parties, including measure developers, measure stewards and other public and private interested parties, to submit candidate quality and efficiency measures for consideration by the Agency as a part of the statutorily required pre-rulemaking process.

Per Section 1890A of the Social Security Act (the Act), the Department of Health and Human Services (HHS) is required to make publicly available, not later than December 1 annually, a list of quality and efficiency measures HHS is considering adopting, through the federal rulemaking process, for use in Medicare programs. This Measures Under Consideration (MUC) List is reviewed by multi-interested party groups who provide recommendations on behalf of the public to HHS no later than February 1 annually. For additional information, please visit the CMS Pre-Rulemaking website.

The following programs are included in the pre-rulemaking process:

Quality Programs

1. Ambulatory Surgical Center Quality Reporting (ASCQR) Program
2. End-Stage Renal Disease Quality Incentive Program (ESRD QIP)
3. Home Health Quality Reporting Program (HH QRP)
4. Hospice Quality Reporting Program (HQRP)
5. Hospital-Acquired Condition Reduction Program (HACRP)
6. Hospital Inpatient Quality Reporting (IQR) Program
7. Hospital Outpatient Quality Reporting (OQR) Program
8. Hospital Readmissions Reduction Program (HRRP)
9. Hospital Value-Based Purchasing (VBP) Program
10. Inpatient Psychiatric Facility Quality Reporting Program (IPFQR)
11. Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)
12. Long-Term Care Hospital Quality Reporting Program (LTCH QRP)
13. Medicare Promoting Interoperability Program
14. Medicare Shared Savings Program (Shared Savings Program)
15. Merit-based Incentive Payment System (MIPS)
16. Medicare Part C and D Star Ratings
17. Prospective Payment System (PPS)-Exempt Cancer Hospital Quality Reporting Program (PCHQR)
18. Rural Emergency Hospital Quality Reporting (REHQR) Program
19. Skilled Nursing Facility Quality Reporting Program (SNF QRP)
20. Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP)

CMS Needs and Priorities

CMS is advancing a modern, outcomes-focused, digitally enabled healthcare system aligned with Administration priorities. CMS's quality measurement strategy is anchored in Make America Healthy Again (MAHA), the transition to digital quality measurement (dQM), and an expanded focus on outcomes and patient-reported experiences. These priorities guide CMS's measurement portfolio and support system-wide modernization across all programs.

CMS's needs and priorities—outlined below—guide how CMS selects, develops, and implements quality measures across programs:

- Modernized, digital reporting systems that reduce burden and improve data quality
- Greater availability of interoperable, all-payer data to support digital quality measurement
- Increased use of outcome and patient-reported outcome measures in programs
- Stronger program alignment to reduce duplication and streamline reporting across CMS

Make America Healthy Again (MAHA)

CMS aims to align quality measures with the MAHA initiative across Quality Reporting and Value-Based Programs. MAHA emphasizes key health improvement priorities, including chronic illness prevention and management; disease prevention across primary (preventing disease onset), secondary (early risk identification and intervention), and tertiary (limiting disease progression and complications) levels; nutrition and healthy dietary habits; physical fitness; and overall wellness.

Digital Quality Measurement (dQM)

CMS continues transitioning to fully digital measures that use interoperable, all-payer data to reduce reporting burden and improve data quality.

Outcome-Focused Measures

CMS is prioritizing outcome measures, patient-reported outcomes (PROs), experience-of-care measures, and metrics that reflect meaningful improvements in patient and population health.

Quality Measurement Strategy

Quality measurement remains a central lever for improving healthcare quality and safety for individuals and communities across the U.S. CMS maintains a portfolio of quality measures that are rigorously tested, high-value, and designed to advance safety, outcomes, patient experience, and equitable care delivery.

Modernization Through Meaningful Measures 2.0

CMS continues to strengthen and streamline measurement through Meaningful Measures 2.0 and the Meaningful Measures Cascade, both of which support alignment, innovation, and efficient measurement across programs.

Meaningful Measures 2.0 focuses on:

- Using only high-value measures in key priority domains
- Aligning measures across CMS programs and partner organizations
- Prioritizing outcome and patient-reported measures
- Transforming measures to be fully digital
- Expanding measurement in prevention, wellness, and chronic disease

Priority Topic Areas

CMS continues to emphasize measurement in areas with the greatest impact on health outcomes, including prevention (primary, secondary, tertiary); physical activity and mobility; nutrition and chronic disease management; safety; behavioral health; maternal health; and appropriate utilization.

Commitment to Transparency

Each CMS program listed in this report is committed to the public reporting of clinical quality measure data. This level of transparency not only educates patients and caregivers about the quality of care and services they seek but also plays an important role in improving the overall quality of healthcare by promoting accountability.

Requirements and Guidance for Submission and Selection to Rulemaking Programs

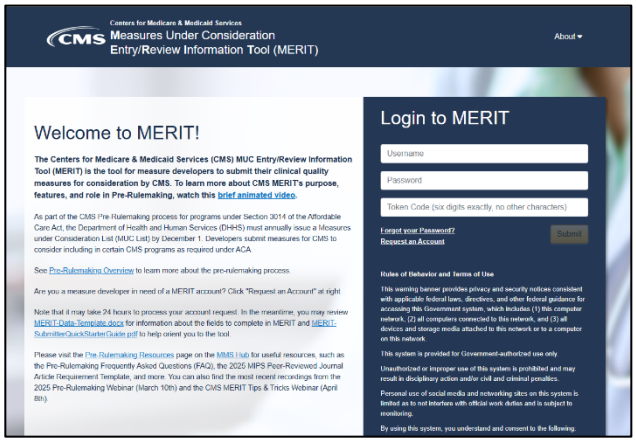
CMS has identified requirements for submitting measures and outlined key considerations for measure selection in future reporting years. To be considered, measures must comply with the submission requirements and guidance listed here.

Measure Submission Requirements

Measures are to be submitted through the CMS MUC Entry/Review Information Tool (MERIT), the web-based system for measure review during the specified submission cycles.

Submissions should include, but not limited to, details such as:

- Title, description, numerator and denominator, exclusions.
- Measure steward.
- Testing and evidence information.
- Estimated impact and cost.
- Data collection mechanism (e.g., CDC National Healthcare Safety Network (NHSN) or Agency for Healthcare Research and Quality (AHRQ) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)).
- For MIPS measures, a peer-reviewed journal article is also required.



CMS is advancing the digital transition to Fast Healthcare Interoperability Resources, or FHIR. FHIR specifications are preferred for pre-rulemaking submissions of the measure, but stewards may submit Quality Data Model (QDM)-based eCQMs.

For **FHIR-based digital quality measures**, you need to attach the following supporting information to your submission in CMS MERIT:

- Measure Authoring Development Integrated Environment (MADiE) human readable file output based on FHIR resources
- MADiE exports of the FHIR-based dQM measure package specified in Quality Improvement Core (QI-Core) 4.1.1 at a minimum (QI-Core 6.0 preferred) ***and*** accompanying test cases with 100% coverage and 100% passing scores
- Attestation that value sets are published in the Value Set Authority Center (VSAC)
- CMS Consensus-based entity feasibility scorecard

If you submit a **QDM-based eCQM**, you need to attach the following supporting information to your submission in CMS MERIT:

- MADiE human readable file output based on the Health Quality Measure Format (HQMF)
- MADiE exports of the eCQM package specified in the QDM and accompanying test cases with 100% coverage and 100% passing scores in both Quality Reporting Document Architecture (QRDA) and Excel format
- Attestation that value sets are published in the VSAC
- CMS Consensus-based entity feasibility scorecard

Measure Submission Guidance

CMS prefers that quality and efficiency measures be fully developed and tested for the appropriate level or setting (e.g., clinician-level for MIPS) and include complete documentation of testing results.

Measures may be part of mandatory or optional quality reporting programs and must fulfill a measurement need. CMS assesses alignment across programs to ensure consistency and avoid duplication.

Important Notes:

- CMS is not obligated to adopt measures listed on the MUC List.
- Measures must have complete and logical specifications.
- Measures should not include proprietary components and should be free for public use.
- Measures included in the MUC List but not selected in the following rulemaking cycle may be reconsidered in future rulemaking cycles.
- CMS prefers a single measure—such as a composite, a multi-score measure, or a measure that includes multiple numerator elements (e.g., screening and follow-up within one specification)—when it can achieve the same outcome as multiple measures aimed at the same goal.
- Resubmission of a measure to the MUC List is only required if:
    - There are substantive changes to specifications (e.g., data source or setting).
    - The measure steward requests consideration for a different program.

Measure Selection Requirements

Selected measures must:

- **Support CMS and national healthcare priorities**, with an emphasis on outcome measures, including patient-reported outcomes, and dQMs.
- **Address program-specific goals and statutory requirements**.
- **Focus on high-priority conditions** with demonstrated performance gaps and a strong evidence base showing the measure can improve outcomes and reduce costs.
- **Include written consent** for any proprietary algorithms or data collection instruments required for measure implementation.
- **Promote alignment** across CMS programs, HHS initiatives, and private payer programs.
- **Identify opportunities for improvement**, ensuring the measure is not "topped out."
- **Minimize unintended consequences**, such as overuse, inappropriate care, or reduced access.
- **Avoid duplication** of measures already implemented in CMS programs.

For more information on measure submission and selection guidance and requirements, please visit the 2026 Guidance & Updates for Measure Submitters section on the MMS Hub or email MMSSupport@Battelle.org.

Overview of Quality Programs

The following sections provide a high-level overview of each program covered by the CMS Pre-Rulemaking process. For more information on current measure details for each program, please visit the CMS Measures Inventory Tool (CMIT), or the latest final rule for each program.

Ambulatory Surgical Center Quality Reporting Program

The Ambulatory Surgical Center Quality Reporting (ASCQR) Program, established under the Medicare Improvements and Extension Act of 2006, requires Ambulatory Surgical Centers (ASCs) paid under the ASC fee schedule to report standardized quality data. The program focuses on improving surgical care quality, patient safety, and outcomes in outpatient settings. Reporting includes claims-based measures using Quality Data Codes (QDCs) and web-based submissions. ASCs that fail to meet requirements face a two-percentage point reduction in their annual payment update. CMS publicly reports ASC performance to promote transparency and improve patient safety, outcomes, and care processes.

Learn more at CMS ASCQR Program page.

End-Stage Renal Disease Quality Incentive Program

The **End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP)**, authorized by Section 1881(h) of the Social Security Act (added by MIPPA 2008), is the first Medicare pay-for-performance initiative. The program focuses on improving dialysis care quality, patient safety, and clinical outcomes for individuals with end-stage renal disease. It links a portion of dialysis facility payments to performance on evidence-based clinical measures and patient experience indicators. CMS selects measures addressing anemia management, dialysis adequacy, infection control, and other priorities, sets performance standards, and calculates a Total Performance Score (TPS). Facilities that fail to meet minimum TPS face up to a 2% payment reduction. Results are publicly reported to promote transparency and continuous improvement in dialysis care.

Learn more at CMS ESRD QIP page.

Home Health Quality Reporting Program

The Home Health Quality Reporting Program (HH QRP), established under Section 1895(b)(3)(B)(v)(II) of the Social Security Act, requires Medicare-certified Home Health Agencies (HHAs) to submit standardized quality data on clinical outcomes, functional status, and patient experience. The program focuses on improving home healthcare quality, patient safety, and functional recovery for individuals receiving care at home. Agencies that fail to report face a 2% reduction in their annual payment update. Data are publicly reported on Care Compare to promote transparency and accountability.

HH QRP measures also inform the expanded **Home Health Value-Based Purchasing (HHVBP) Model**, which was authorized under Section 1115A of the Affordable Care Act and initially implemented in nine states. As of CY 2022, HHVBP expanded nationwide to all Medicare-certified HHAs. The model adjusts payments by up to ±5% based on quality performance and currently uses a set of measures including claims-based, OASIS-based, and CAHPS patient satisfaction measures. Public reporting for HHVBP began in January 2025 on the CMS Provider Data Catalogue (PDC).

Learn more at CMS HH QRP page.

Hospice Quality Reporting Program

The Hospice Quality Reporting Program (HQRP), established under Section 1814(i)(5) of the Social Security Act as amended by the Affordable Care Act and the Consolidated Appropriations Act of 2021, requires Medicare-certified hospices to submit standardized quality data for all patients, regardless of payer. The program focuses on improving end-of-life care quality, symptom management, and family support for hospice patients. These data include clinical outcomes, care processes, and patient and family experience measures. Hospices that fail to report face a payment reduction—2% beginning in FY 2014, which increased to 4% starting in FY 2024. HQRP results are publicly reported on Care Compare.

Learn more at CMS HQRP page.

Hospital-Acquired Condition Reduction Program

The Hospital-Acquired Condition Reduction Program (HACRP), established under Section 1886(p) of the Social Security Act, incentivizes hospitals to reduce preventable hospital-acquired conditions (HACs). The program focuses on improving patient safety by reducing infections and adverse events during hospital stays. Effective FY 2015, the program scores hospitals using the CMS Patient Safety and Adverse Events Composite (PSI 90) and five healthcare-associated infection measures reported via CDC's NHSN. A hospital's Total HAC Score, calculated as the equally weighted average of its measure scores, determines its ranking. The Secretary is required to make payment adjustments to hospitals that rank in the worst-performing quartile nationally based on these scores. HACRP results are publicly reported on Care Compare.

Learn more at CMS HACRP page.

Hospital Inpatient Quality Reporting Program

The Hospital Inpatient Quality Reporting (IQR) Program, established under Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and expanded by the Deficit Reduction Act of 2005, requires acute care hospitals paid under the Inpatient Prospective Payment System (IPPS) to submit standardized quality data on clinical outcomes, patient safety, and experience measures. The program focuses on improving inpatient hospital care quality, patient safety, and overall patient experience. Hospitals that fail to meet reporting requirements face a reduction of one-quarter of their Annual Payment Update (APU). Certain hospital types, such as critical access hospitals and facilities in Puerto Rico and U.S. territories, are excluded from penalties but may voluntarily report for public display. Performance data are publicly reported on Care Compare.

The **Hospital IQR Program** and **Medicare Promoting Interoperability Program** have a completely aligned eCQM measure set in each program. Hospitals receive credit for both programs by submitting eCQM files just once through the Hospital Quality Reporting System. Critical Access Hospitals (CAHs) are not required to report under the Hospital IQR Program but are required to report under the Medicare Promoting Interoperability program. Participants in the Medicare Promoting Interoperability Program are also required to report on four scored objectives and their measures (i.e., Electronic Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange) and required to report (yes/no) on the Protect Patient Health Information objective among other programs requirements.

Learn more at CMS Hospital IQR Program page.

Hospital Outpatient Quality Reporting Program

The Hospital Outpatient Quality Reporting (OQR) Program, established under Section 109 of the Tax Relief and Healthcare Act of 2006, is a Medicare pay-for-reporting initiative that requires subsection (d) hospitals paid under the Outpatient Prospective Payment System (OPPS) to submit standardized quality data. The program focuses on improving outpatient care quality, efficiency, and patient experience in hospital settings. Measures address process, structure, outcomes, efficiency, cost of care, and patient experience. Hospitals that fail to meet reporting requirements receive a two-percentage point reduction to their APU under OPPS. Performance data are publicly reported on Care Compare.

Learn more at CMS Hospital OQR Program page.

Hospital Readmissions Reduction Program

The Hospital Readmissions Reduction Program (HRRP), established under Section 1886(q) of the Social Security Act, is a Medicare value-based purchasing initiative that reduces payments to subsection (d) hospitals with excess readmissions. The program focuses on improving care transitions, reducing avoidable hospital readmissions, and enhancing patient outcomes after discharge. Effective FY 2013, HRRP evaluates hospitals on readmission rates for conditions such as heart failure, pneumonia, COPD, and others. Under the 21st Century Cures Act, CMS uses a peer grouping methodology (since FY 2019) to compare hospitals within quintiles based on the proportion of dual-eligible beneficiaries, ensuring fairness and budget neutrality.

Payment reductions are calculated by:

1. Computing an excess readmission ratio (ERR) for each condition using Medicare fee-for-service (FFS) claims.
2. Determining each hospital's dual-eligible proportion using Medicare FFS and managed care claims.
3. Sorting hospitals into five peer groups (quintiles) based on hospitals' dual proportions.
4. Identifying the median ERR for each condition within each peer group.
5. Determining measures where ERR exceeds the peer group median and meets the minimum 25 discharge threshold.
6. Calculating each measure's contribution to the reduction and applying a Payment Adjustment Factor (PAF).

Learn more at CMS HRRP page.

Hospital Value-Based Purchasing Program

The Hospital Value-Based Purchasing (VBP) Program, established under Section 3001(a) of the Affordable Care Act, provides annual value-based incentive payments to hospitals that meet performance standards for a defined period. The program focuses on improving hospital care quality, patient safety, experience, and cost efficiency through performance-based payment adjustments. The program adjusts payments based on performance across domains such as clinical outcomes, patient experience, safety, and efficiency, and includes a required cost-efficiency measure (Medicare Spending Per Beneficiary). Measures must be publicly reported for one year before adoption. In FY 2024, CMS modified the scoring methodology to reward hospitals serving underserved populations by applying bonus points to their TPS based on performance and the proportion of dual-eligible patients.

Learn more at CMS Hospital VBP Program page.

Inpatient Psychiatric Facility Quality Reporting Program

The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program, established under Section 1886(s)(4) of the Social Security Act and amended by Section 4125(b) of the Consolidated Appropriations Act, 2023, requires psychiatric hospitals and psychiatric units paid under the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS) to submit standardized quality measures. The program focuses on improving psychiatric inpatient care, including patient safety, care coordination, medication management, and patient experience. IPFQR is a pay-for-reporting program; facilities that fail to comply receive a two-percentage point reduction to their market basket update, effective October 1 of each fiscal year. Performance data are publicly reported on Care Compare.

Learn more at CMS IPFQR Program page.

Inpatient Rehabilitation Facility Quality Reporting Program

The **Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)**, established under Section 1886(j)(7) of the Social Security Act as amended by Section 3004(b) of the Affordable Care Act of 2010 and implemented with the FY 2012 IRF PPS Final Rule, requires inpatient rehabilitation facilities to submit data on quality measures and standardized patient assessment data elements. The program promotes high-quality, patient-centered care for individuals receiving intensive rehabilitation services by focusing on clinical outcomes, functional status, patient safety, and care processes. IRF QRP is a pay-for-reporting program; facilities that fail to meet reporting requirements incur a two-percentage point reduction to their Annual Increase Factor (AIF) for future fiscal year payments. Performance data are publicly reported on Care Compare.

Learn more at CMS IRF QRP page.

Long-Term Care Hospital Quality Reporting Program

The Long-Term Care Hospital (LTCH) Quality Reporting Program (QRP), established under Section 3004(a) of the Affordable Care Act of 2010 and implemented with the FY 2012 Inpatient PPS/LTCH PPS Final Rule, requires long-term care hospitals to submit standardized quality data to promote high-quality, patient-centered care for individuals requiring extended hospital stays. LTCHs must meet two separate data completeness thresholds each fiscal year: at least 85% for quality measure data collected using the LTCH Continuity Assessment and Record Evaluation (CARE) Data Set (LCDS) and 100% for data submitted through the CDC NHSN. LTCH QRP is a pay-for-reporting program; facilities that fail to meet these requirements incur a two-percentage point reduction to their Annual Payment Update. The program focuses on improving care quality, patient safety, and outcomes for medically complex patients, and performance data are publicly reported on Care Compare.

Learn more at CMS LTCH QRP page.

Medicare Promoting Interoperability Program

The **Medicare Promoting Interoperability Program**, originally launched as the Medicare EHR Incentive Program under the Health Information Technology for Economic and Clinical Health (HITECH) Act, is authorized by Sections 1886(b)(3)(B)(ix) and 1814(l)(4) of the Social Security Act, as amended by the American Recovery and Reinvestment Act of 2009. The program requires eligible hospitals and critical access hospitals (CAHs) to demonstrate meaningful use of certified electronic health record technology (CEHRT) during applicable EHR reporting periods to avoid downward payment adjustments, which began in FY 2015. Section 602 of the Consolidated Appropriations Act, 2016 extended eligibility to subsection (d) hospitals in Puerto Rico, with payment adjustments starting in FY 2022 for hospitals that fail to meet requirements. The program promotes secure health information exchange, care coordination, and patient engagement through digital interoperability by requiring reporting on measures such as electronic prescribing, health information exchange, and patient access to health data.

Learn more at CMS Promoting Interoperability Program page.

Medicare Shared Savings Program

The Medicare Shared Savings Program (MSSP), established under the Affordable Care Act, is Medicare's national value-based payment program for Accountable Care Organizations (ACOs). The program encourages eligible clinicians, hospitals, and other providers to voluntarily join or form ACOs to improve care quality, enhance care coordination, and reduce the growth of Medicare Fee-for-Service (FFS) costs. ACOs that meet quality performance standards and achieve savings share in those savings, while those participating in two-sided risk models may owe losses if costs increase, with repayment amounts tied to quality performance and track.

Learn more at CMS Shared Savings Program page.

Merit-based Incentive Payment System

The Merit-based Incentive Payment System (MIPS), established under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), is a key component of the Quality Payment Program (QPP) that incentivizes clinicians to deliver high-quality, cost-efficient care to Medicare beneficiaries. MIPS consolidates three legacy programs—the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Medicare EHR Incentive Program for Eligible Professionals—into a single, performance-based payment system. Clinicians are assessed across four categories: Quality, Cost, Promoting Interoperability, and Improvement Activities, with each category contributing to a final score that determines payment adjustments. Participants may choose between traditional MIPS or MIPS Value Pathways (MVPs), which streamline reporting by focusing on measures relevant to specific specialties or conditions. Through these pathways, MIPS promotes clinical excellence, efficiency, and patient-centered care, fostering continuous improvement and advancing value-based care.

Learn more at CMS MIPS page.

Part C and D Star Ratings

The Medicare Part C and D Star Ratings Program, authorized under Sections 1851(d), 1852(e), 1853(o), and 1854(b)(3) of the Social Security Act, evaluates the performance of Medicare Advantage (Part C) and Prescription Drug (Part D) plans using a 5-star rating system. Codified in the CY 2019 Medicare Part C and D Final Rule, the program measures plan quality based on clinical care, medication safety, patient experience, customer service, and care coordination. Star Ratings support CMS's Quality Strategy goals of improving health outcomes, enhancing patient-centered care, and reducing costs. High-performing plans (5 stars) receive a High Performing Icon (HPI) and may enroll beneficiaries year-round through a Special Enrollment Period, while low-performing plans (less than 3 stars for three consecutive years) display a Low Performing Icon (LPI), triggering beneficiary eligibility for a Special Enrollment Period to switch plans. Under the Affordable Care Act, CMS provides Quality Bonus Payments (QBPs) and adjusts rebate levels based on Star Ratings, incentivizing continuous improvement and transparency. Ratings are published annually on **Medicare.gov** to help beneficiaries make informed choices and promote competition among plans.

Learn more at CMS Star Ratings Program page.

Prospective Payment System-Exempt Cancer Hospital Quality Reporting Program

The PPS-Exempt Cancer Hospital Quality Reporting Program (PCHQR), established under Section 1866(k) of the Social Security Act, promotes transparency and quality improvement in cancer care at hospitals exempt from the IPPS. These specialized hospitals are required to submit data on selected quality measures to CMS, focusing on clinical outcomes, patient safety, and care coordination. While participation does not affect payment, the program fosters accountability by publicly reporting performance data on the PDC.

Learn more at CMS PCHQR Program page.

Rural Emergency Hospital Quality Reporting Program

The Rural Emergency Hospital Quality Reporting (REHQR) Program, established under Section 1861(kkk)(7) of the Social Security Act as added by the Consolidated Appropriations Act of 2021, is a CMS initiative designed to promote high-quality, safe, and efficient care in rural emergency hospitals (REHs), a new Medicare provider type. REHs are facilities that, as of December 27, 2020, were either a critical access hospital (CAH) or a subsection (d) hospital with no more than 50 beds that was treated as rural under Section 1886(d)(8)(E). Eligible hospitals could begin converting to REHs on January 3, 2023. The program requires REHs to submit standardized quality measures—potentially including claims-based measures and patient experience surveys—through the Hospital Quality Reporting Secure Portal, overseen by a designated Security Official. Existing hospital accounts may be updated with the new REH Medicare identifier for compliance. Quality data collected through REHQR will be publicly reported on a CMS website to support transparency and informed decision-making for patients and communities. While participation does not impact payment, the program fosters accountability and continuous improvement in rural emergency care.

Learn more at CMS REHQR Program page.

Skilled Nursing Facility Quality Reporting Program

The Skilled Nursing Facility (SNF) Quality Reporting Program (QRP), established under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 and implemented through the FY 2016 SNF Prospective Payment System (PPS) Final Rule, is a CMS initiative designed to promote high-quality, patient-centered care for individuals receiving skilled nursing services. SNF QRP is a pay-for-reporting program that requires facilities to submit standardized patient assessment data and quality measures related to functional status, clinical outcomes, and care coordination. Failure to meet reporting requirements results in a two-percentage point reduction to the facility's Annual Payment Update. Performance data are publicly reported on Care Compare.

Learn more at CMS SNF QRP page.

Skilled Nursing Facility Value-Based Purchasing Program

The Skilled Nursing Facility (SNF) Value-Based Purchasing Program, established under the Protecting Access to Medicare Act (PAMA) of 2014, is a CMS initiative that incentivizes skilled nursing facilities to improve the quality of care for Medicare beneficiaries. The program adjusts facility payments based on performance on quality measures, currently focused on reducing hospital readmissions and improving care transitions. CMS withholds 2% of SNF Medicare Fee-for-Service payments to fund the program, redistributing a portion as incentive payments to high-performing facilities. SNF VBP promotes better outcomes, care coordination, and accountability by rewarding facilities that deliver high-quality care, including those serving a higher proportion of dual-eligible residents. This approach aligns with CMS's broader strategy to advance equity and value-based care across Medicare programs.

Learn more at CMS SNF VBP Program page.

For more information, email the Measure Management Support Team at MMSSupport@battelle.org